

September 2006

Regulation of Health Professions in Ontario: **New Directions**

A Report to the
Minister of Health
and Long-Term Care
on Regulatory
Issues and
Matters respecting
Personal Support
Workers



Submitted by the
**Health Professions
Regulatory Advisory Council
(HPRAC)**



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Ontario

September 29, 2006

Hon. George Smitherman
Minister of Health and Long-Term Care
10th floor, Hepburn Block
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Dear Minister,

The Health Professions Regulatory Advisory Council is pleased to submit to you its report respecting the regulation of Personal Support Workers in response to your referral letter of February 7, 2005. Your request for advice was very challenging given the range of work undertaken by personal support workers, and the sites where they carry out their duties. Additionally, a significant amount of existing legislation affects employers, facilities and institutions.

We have attempted to identify key issues regarding the training and work of personal support workers, and the impact on patients of their services. This report follows the interim report that was included in our "New Directions" report submitted in April, 2006, which is appended to this document. In this report, we propose alternatives for your consideration, along with additional information.

We look forward to discussing this further with you.

Yours truly,

Barbara Sullivan, Chair

Peter Sadlier-Brown, Vice-Chair

Barry Brown

Kevin Doyle

Ennis Fiddler

Mary Mordue

The Regulation of Personal Support Workers

The Minister's Question

On February 7, 2005 the Honourable George Smitherman, Minister of Health and Long-Term Care, asked the Health Professions Regulatory Advisory Council (HPRAC) to:

Review the range of work carried out by Personal Support Workers (PSWs) and make initial recommendations on whether all or some part of this range would indicate that Personal Support Workers should be considered for regulation under the [Regulated Health Professions Act, 1991] RHPA.¹

In April 2006, HPRAC submitted an interim report on this question to the Minister, as part of *New Directions: A report to the Minister of Health and Long-term Care on Regulatory Issues and Matters Respecting Health Care Practitioners, Patients and Clients (April 2006)*. That report identified several issues regarding the role of PSWs in the delivery of vital services to vulnerable populations, including the disabled population, the frail elderly and those recovering from medical treatments. While there was consensus on some matters from those who responded to HPRAC's first consultative round, the need for further information on key issues became apparent.

The *New Directions* report (page 248) made the following initial recommendations concerning the regulation of PSWs:

1. That there should be no change to Section 29 (1) (e) of the RHPA that excepts individuals "assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27 (2)."
2. HPRAC has completed the initial phase of work in response to the Minister's request for advice, and will offer final recommendations in September 2006.

Following the interim report, HPRAC initiated phase II of the review to explore outstanding issues and questions arising from the findings in the first phase of the review. Specifically, HPRAC:

- Undertook additional public consultations in locations across Ontario. These forums sought input from clients, patients and PSWs.
- Examined the practical application of regulatory options and alternatives to regulation identified during phase I.
- Conferred with Ministry of Health and Long-Term Care officials about pending changes in regulations governing long-term care providers and community care.

¹ Minister's Referral Letter, February 7, 2005.

This report incorporates findings from these initiatives. It focuses on the question of regulation, including the merits of self regulation for PSWs, potential for a PSW registry, adequacy of supervision, and standardization of training and education. In addressing these questions, HPRAC considered the settings in which PSWs work, and how these issues are being addressed in each setting.

HPRAC's Response

HPRAC's central recommendation to the Minister is that Personal Support Workers should not be regulated as a profession under the *Regulated Health Professions Act*. HPRAC also concludes that the closest alternate form of regulation - a Personal Support Worker Registry - should not be implemented.

HPRAC recommends that additional steps be taken within the current system to improve the education and training of PSWs and their staffing and supervision. There should also be better access to more satisfactory recourse for patients and clients as a means of addressing instances of abuse and misconduct.

History of the Referral

Prior to the current referral, the work performed by PSWs had not been reviewed within the framework of the *RHPA*. PSWs provide the major part of personal support services in home care and in long-term care facilities under the supervision of regulated professionals. In recent years, there has been a significant move to treat more patients requiring increasingly complex care at home. This is in response to patient demand, earlier discharge from hospital and to the finding that patients respond well to care at home or in the community. Demographic changes, including longer life spans, increases pressure on Long-Term Care homes, with patients requiring multifaceted care.

1. The Consultation Process

The consultation and research processes for both phases of this project were extensive. Interviews were held with individual PSWs and groups representing PSWs; education and training institutions; regulated health professional colleges; organizations and associations representing providers, consumers, facilities and disease support organizations; and advocacy associations. The information provided reflected the experience of individual organizations and included changing demographics, PSW roles and responsibilities, work environment, educational requirements, guidelines governing PSW work, client descriptions and current issues.

HPRAC hosted a number of workshops and public meetings to examine the role of PSWs, the tasks they perform, work settings, variability of work, conditions of

employment, human resource challenges, education and training, client concerns and risk of harm to patients and clients.

Findings derived from these activities were synthesized into a Discussion Guide, along with questions to which stakeholders were invited to respond. Forty-three written submissions were received from employers, PSWs, regulated health professions, consumers, educators and representatives from interest and advocacy groups. Thirty-two subject matter experts were also interviewed.

A review of other jurisdictions and current literature was undertaken. Material from Nova Scotia, the United States, the United Kingdom and Australia was reviewed and analyzed to determine how regulation has been approached for people whose work is similar to PSWs.

These activities provided substantial feedback on what key stakeholders say are matters of concern. Contributors commented on the:

- Role of PSWs and the work they perform.
- Potential for harm to a patient or client and what constitutes harm or abuse.
- Education and training for PSWs, their supervisors and employers.
- Presence of alternative governance frameworks, including legislation and regulations, that impact on the work, roles and accountability of personal support workers in the current work environment.
- Alternatives to regulation under the *RHPA*.

These consultations highlighted two key issues: significant diversity of work carried out by PSWs in different job settings and, in some situations, concerns regarding overlap with scopes of practice reserved for regulated health care professionals. HPRAC was told that, in a number of cases where PSWs were doing work within the scope of practice of RNs and RPNs, this work was being performed under delegation or supervision. However, HPRAC also heard concerns that the supervision may not always be adequate.

The second phase of consultations involved public hearings in a number of communities across the province, where HPRAC purposefully sought input from PSWs, their clients and patients. Approximately 40 participants presented responses to the Discussion Guide at hearings held in Ottawa, Toronto, Etobicoke, Thunder Bay and London during May and June, 2006. Others made written submissions in response to the Discussion Guide. HPRAC conducted two focus groups with individuals with disabilities and their representatives. HPRAC also conducted five key informant interviews with the College of Nurses, nursing associations and employers of PSWs.

A more detailed assessment of the appropriateness of regulation of PSWs under the *RHPA* followed. In the preparation of its recommendations to the Minister, HPRAC received and analysed stakeholder comments on economic impacts, access, and creating a "best practice" culture.

2. Background

2.1 What is a Personal Support Worker?

Personal Support Workers are front line workers who play a key role in private, group living and facility-based settings. PSWs work in hospitals and acute care facilities. They work in long-term care homes, private homes and community home care. Patients and clients receiving services from PSWs have a wide spectrum of needs and conditions. The interaction of PSWs with clients may affect the day-to-day function and overall wellness of those individuals. The level of supervision under which PSWs work varies by setting and by the availability of regulated professionals on staff.

As HPRAC learned there is no uniformly accepted definition of a personal support worker. The category is often defined by job descriptions on file with employers. These vary by sector, setting and by patient or client needs. Two descriptions follow:

Personal Care Workers deliver quality care, assistance and support services to people in their own homes during times of need. The duties of home support workers vary according to the situation.²

Personal Support Worker[s]...provide long-term care and support to patients and clients. Work responsibilities include personal care, housekeeping duties, shopping and companionship. The abilities of the Personal Support Worker are critical to the well being, comfort, safety and health of the people they support.³

2.2 Demand for Services

The demand for PSWs is increasing. The aging population will continue to experience increased incidence of chronic disease and complex conditions that may be managed at home and in long-term care facilities.⁴ In long-term care homes, the changing client base has prompted an increased focus on chronic disease management and dementia. The average age of residents in long-term care is 82.7 years. More than 85 per cent are classified in the mid-to-heavy care categories. Overall, 73 per cent of residents have some form of mental disorder, including people with Alzheimer's disease and related dementias.

² Canada Career Consortium. *Home Support Worker/Home Health Aide*.

http://www.careerccc.org/careerdirections/eng/e_oc_dwn.asp?ID=97&Alpha=No. Accessed February 13, 2006.

³ Ontario Hospital Association. Health Care Job Descriptions.

http://www.oha.com/client/OHA/OHA_LP4W_LND_WebStation.nsf/page/Health+Care+Job+Descriptions Accessed February 12, 2006.

⁴ In contrast to the overall population (whose growth rate is 1.2 to 1.3 per cent), those aged sixty-five and older are increasing by 1.7 per cent per year and life expectancies continue to rise. HPRAC, *New Directions*, April 2006.

In home care, the trend to early patient discharge from hospitals is leading to an increase in acuity among home care clients and in the complexity of services provided outside of the hospital. Technological advances also mean that persons with disabilities are able to receive care and services that facilitate independent living. This too, has resulted in an increase in complex conditions now managed at home or in the community.

Province-wide health human resource challenges have contributed to the increasing demand for allied health care workers such as PSWs in all care settings. Other trends impacting the role of PSWs and their scope of work include:

- Increasing demand for services based on growth in absolute numbers of the seniors population.
- Continuing interest in replacing traditional models of hospital-based care with community-based services.
- Increasing acuity of residents in both long-term care homes and clients in community settings as a result of shorter acute care stays.
- Client preferences for aging in place.
- Fewer informal caregivers in the home.
- New technologies.

2.3 Roles fulfilled by Personal Support Workers

Personal Support Workers are employed in a variety of public and private sector settings. As noted above, they work in long-term care homes, home care and private settings such as retirement homes and private homes. Individuals now generically described as PSWs were previously known by a variety of other job titles, including: health care aides, personal attendants, home supporters, visiting homemakers, respite care workers, palliative care workers and supportive care assistants.

The work of PSWs ranges from home-making tasks to performing controlled acts under delegation. Some PSWs have little or no formal education. Anecdotal evidence suggests that there are a significant number of PSWs who have not completed a formal training program. Some rely on previous work in related occupations; others bring healthcare training they received in another country. Many are trained in-service by employers or through not-for-profit organizations. Others receive formal training in community colleges, career colleges and from boards of education.

Some of the functional tasks performed by PSWs include activities of daily living (ADL) such as light housekeeping, personal care (bathing, feeding, dressing, toileting), and transferring responsibilities (helping an individual into or out of bed). In some instances, child care may be involved. Other tasks involve instrumental activities of daily living (IADL) and may include menu planning, shopping and meal preparation or providing

transportation and accompanying clients to and from appointments. Educational and recreational assistance may also be provided. In some instances, PSWs are called on to provide clinical care services where they measure a client's blood pressure, temperature or pulse, take specimens or implement a rehabilitation program.

Where very specific criteria have been satisfied, PSWs may perform delegated or authorized acts that involve:

- Administering a substance by injection or inhalation.
- Putting an instrument, hand or finger into a body orifice or artificial opening into the body.⁵

Examples of the performance of controlled acts under delegation include administration of medications, suppositories, colonic irrigations or enemas.

Also of note, the work of PSWs may overlap significantly with the work of individuals holding other job titles.

2.4 The Workforce

A number of factors make it difficult to accurately estimate the size of the PSW workforce in Ontario:

- Data sources often put PSWs into categories with other health care professionals. For example, Health Canada does not distinguish PSWs as a stand-alone occupational category. Instead, PSWs are grouped with related occupations such as Patient Service Associate, Attendant Care Worker and Visiting Homemaker. The College of Nurses of Ontario (CNO) places PSWs into a broad category of "Unregulated Care Providers (UCPs)."
- There are several educational and training paths leading to employment as a PSW which confounds attempts to estimate the size of the workforce.
- Many employers rely on part-time or casual workers to meet variable demands for services. Consequently, they add up hours worked and report on Full Time Equivalent (FTEs) positions rather than staff positions in their employ.

Health Canada data indicates that approximately 100,000 people are estimated to be working as PSWs or performing similar roles in Ontario.⁶ Health Canada data also reveals that this is a rapidly growing workforce with a low unemployment rate.

⁵ College of Nurses of Ontario, *Practice Guideline: Working with Unregulated Care Providers*, 2005.

⁶ This number is a composite derived from information collected from a variety of sources, including reports on long-term care facilities, employer and association websites and relevant studies. Three factors may affect its accuracy. 1) The number of PSWs hired privately, making total employment potentially higher. 2) Some individuals who perform the same core tasks as many PSWs may work under other job titles and, therefore, not identify with the occupational group. This would reduce the reported size of the

2.5 Workforce by Employment Setting

PSWs provide services and direct care to individuals in hospitals, long-term care homes, supportive living environments, as well as in private surroundings such as the client's own home or a retirement residence. They work with clients who have a broad spectrum of conditions and health care needs. Services may be provided on a temporary or continuing basis.

Hospitals

In hospitals, PSWs work primarily in rehabilitation and complex continuing care, and are generally known as health care aides. In these settings, PSWs support ADL and activation activities to assist people in dealing with aging, injury or illness. A PSW works under the direction of a Registered Nurse or Registered Practical Nurse.⁷ They may assist nurses, hospital staff and physicians.⁸ They may also receive direction from occupational therapists, physiotherapists and registered respiratory therapists.

Long-Term Care

Long-Term Care has changed significantly over the past few years with an increased focus on serving clients with chronic diseases and dementia. The scope of work for PSWs in this setting includes assistance with ADL, recreation, ambulation and carrying out delegated nursing acts.

HPRAC was told that the majority of PSWs working in Long-Term Care have completed community or career college programs. Follow-up training is usually provided by the employer.

Numerous regulations, legislation and standards in Ontario have an impact on the operation of Long-Term Care homes and the conduct of employers.

Community Care

A significant number of PSWs working in home care are employed by agencies contracted by Community Care Access Centres (CCACs). These agencies hire PSWs to work in clients' homes where they are primarily responsible for ADL, IADL, and client-specific personal and or clinical care needs. The client population varies widely. The number of post-acute clients is increasing as patients are released more quickly from

workforce. 3) Some employers record full-time equivalent (FTE) positions rather than full-time staff. This potentially inflates their 'head-count' where, for example, a single PSW was picking up double shifts for one or more employers.

⁷ Ontario Network for Internationally Trained Professionals Online. Personal Support Worker. <http://www.onip.ca/article/8/>. Accessed February 12, 2006.

⁸ Ontario Job Futures. 3413 *Nurse Aides, Orderlies and Patient Service Associates*. Government of Ontario. <http://www1.on.hrdc-drhc.gc.ca/ojf/ojf.jsp?lang=e&section=Profile&noc=3413>. Accessed December 13, 2005.

hospitals and as a follow-up to ambulatory procedures. Other clients require on-going care to manage chronic conditions. Clients span all age groups.

Community Support Agencies also hire PSWs to provide services primarily to the elderly and individuals living with physical disabilities. The role of the PSW varies with the agency's mandate. Some agencies provide home help, while others provide respite care. In each of these situations, the PSW is likely to provide IADL and ADL assistance.

Many PSWs employed in this sector work split shifts and hold multiple jobs; 92 per cent are female.⁹

Private Employment

PSWs may be employed in private arrangements with clients. In private homes, independent living is the primary focus of the services provided. Though diverse, clients typically require help with ADL, IADL, and homemaking duties. Recreation and activities fostering socialization are other tasks that the PSW may carry out.

Costs may be borne privately by the client or funded through private insurance. Costs also may be offset by special-purpose programs. For example, the Department of Veteran Affairs (DVA) subsidizes house and grounds-keeping for veterans and surviving spouses.

Another private sector employer is private retirement homes. There are approximately 650 privately-run retirement residences in operation across the province, housing close to 40,000 residents. The Ontario Retirement Communities Association (ORCA) represents approximately 60 per cent of the retirement homes in Ontario. The Ontario Seniors Secretariat has acknowledged ORCA for implementing an accessible complaints response and information service including a 1-800 contact number. ORCA accredits and inspects members' residences to ensure that they demonstrate a commitment to quality and accountability. Association policies specify zero tolerance for abuse. One of its larger members noted that the "overwhelming majority" of its employees have formal training.¹⁰

HPRAC notes that while progress has been made by ORCA to improve quality of care among its members, 40% of private retirement homes are not members, and may not adopt the same level of standards of care.

3. Factors Informing HPRAC's Recommendations

3.1 Body of Knowledge

In preparing its advice on the regulation of new professions, HPRAC considers whether

⁹ Ontario Job Futures. "6471 Visiting Homemakers, Housekeepers and Related Occupations". Government of Ontario. <http://www1.on.hrdc-drhc.gc.ca/ojf/ojf.jsp?lang=e&section=Profile&noc=6471>. Accessed December 13, 2005.

¹⁰ Diversicare Canada Management Services Co. Inc., Submission to HPRAC, May 2006.

the members of the profession can call upon a distinctive, systematic body of knowledge in assessing, treating or serving a professional group's clients or patients. The core activities performed by members of the profession must be discernible as a clear integrated whole and must be broadly accepted as such within the profession.

HPRAC repeatedly heard that there is no definitive body of knowledge unique to the PSW occupation. The Registered Nurses Association of Ontario (RNAO) has observed that PSWs do not practice within a distinctive systematic body of knowledge, but follow a clearly defined plan of care defined by the employer and/or supervisor.¹¹

The College of Nurses of Ontario stated that:

The work of PSWs is directed by a plan of care developed by a regulated care provider. The PSW does not organize the care plan, but is responsive to it in supporting the client. The PSW does not perform an assessment. The circumstances in which a PSW may perform treatments are carefully prescribed under the direction and supervision of a regulated health professional. Most importantly, where the PSW receives instruction in performing activities that may be within the nursing scope of practice, the instruction is tailored to individual clients. The PSW does not have the educational training to transfer these skills to other clients.¹²

This view was shared by educators. For example, George Brown College of Applied Arts and Technology, said:

Most critically, PSWs do not practice within a distinctive systematic body of knowledge, but rather follow a clearly defined plan of care defined by the employer or a regulated care provider. Where PSWs are required to perform delegated duties that are within the nursing scope of practice, the nurse must ensure that the PSW is able to accept this delegation. In doing so, the PSW is directed by and responsive to a plan of care for a specific patient, developed by a regulated care provider, and is instructed to provide care specifically tailored to an individual patient.¹³

In some circumstances, PSWs are delegated controlled acts by a regulated health professional. As reported, this delegation is client-specific and does not mean that PSWs are assessing or treating their own patients or clients. At all times, they are playing a supportive role by assisting regulated health professionals in carrying out care and treatment plans.

Some have argued that the body of knowledge of PSWs is basic nursing care, and that PSWs are now doing what was done in the past only by RNs and RPNs. Others disagree,

¹¹ Letter from the Registered Nurses Association of Ontario (RNAO) to HPRAC, June 2006.

¹² College of Nurses of Ontario, Response to Consultation Discussion Guide, March 2006.

¹³ George Brown Community College, Submission to HPRAC, June 2006.

saying that with increased educational standards for RNs (BSc) and RPNs (College diploma), the tasks performed by PSWs are no longer part of nursing care. The CNO argues that the scope of practice of PSWs encompasses solely activities that the client would do for himself or herself if physically or cognitively able and that PSWs do not exercise independent judgement, nor do they make decisions in the care of patients but simply follow care and treatment plans developed by regulated health professionals.¹⁴

HPRAC views the work of PSWs as being distinct from that of nursing. As well, HPRAC is of the view that PSWs closely follow the care and treatment plans of others. Overall, PSWs do not have the authority to initiate any action with respect to a patient – they cannot make independent changes to the plan of care or the implementation of the care plan. Furthermore, record management activities undertaken by PSWs are routine, and do not involve judgments about the records they maintain.

HPRAC is therefore of the view that the PSW occupation does not operate within its own clearly defined body of knowledge.

3.2 Risk of Harm

To qualify for self-regulation under the *RHPA*, a profession must demonstrate that there is a substantial risk of physical, emotional or psychological harm to persons in their care stemming from the practice of their profession. During phase I of HPRAC's review, several participants associated the work performed by PSWs with the possibility of harm ranging from injury by mishap (during the performance of ADL/IADL tasks) to harm originating from the performance of delegated acts, and harm as a result of misconduct. In the second phase of its investigation, HPRAC heard specific examples.

Commenting on the risks, the College of Nurses of Ontario stated that:

...as the quality and extent of supervision to PSWs decreases, the risk of harm to patients increases...When PSWs are providing basic care [in keeping with their] educational training and reinforced by employer service standards, risk of harm is minimized...Where PSWs are providing care that is outside their scope of training and usual work, the degree of supervision must relate to the complexity of the procedure and the client's condition.¹⁵

The Registered Practical Nurses Association of Ontario (RPNAO) illustrated how the routine performance of a delegated act can become a therapeutic intervention.

...circumstances can arise when a PSW is performing a controlled act under delegation, but the patient's condition changes and the procedure being performed becomes a therapeutic nursing intervention. In many cases the PSW does not have the knowledge, skill or judgement to know that a change has occurred, will not

¹⁴ Letter from the College of Nurses of Ontario (CNO) to HPRAC, June 2006.

¹⁵ Ibid.

recognize the additional complexities of the case including contraindications to the treatment being provided and, as a result, may put the patient at risk.

For example...regular suctioning of well established tracheostomies is a routine ADL. However, the patient could develop...complications evidenced, for example, by discolouration of the fluid being suctioned. The PSW cannot be assumed to [recognize] that a change in the patient's condition has occurred [although] in good faith they [believe] they are properly performing [the task].¹⁶

In addition, a PSW may be the only worker present when a patient or client experiences a change in condition. Their actions may affect the outcome of a patient or client in an emergency.

One employer, Diversicare Canada Management Services, discussed risks of harm to patients or clients through PSW misconduct in these terms:

Even where zero tolerance is enforced and protections are promoted...no employer...can monitor the regular interactions between PSWs...and their clients. While the overwhelming number of our employees are caring, compassionate individuals well-suited to their role as care and service providers, the reality is that exceptions exist. There are people who...take advantage of the client group's vulnerability.¹⁷

Physical or Mental Harm from Treatment

In the context of a profession's suitability for regulation under the *RHPA*, the Advisory Council's central focus is on physical or mental harm from treatment. The extent of the risk of physical or mental harm from care provided by PSWs is complicated by the fact that they are not independently planning and providing treatment. They are acting under the supervision or direction of a regulated professional or employer who is responsible for the care or treatment plan.

Harm to patients arises from improperly following instructions or modifying a care plan when not authorized to do so. For example, if a PSW failed to adhere to a client's therapeutic diet, harm could result. There is also the general risk of error or injury due to the unplanned substitution of a client's regular PSW, or from fatigue where a PSW is working extra shifts. In this situation, HPRAC is of the view that workplace practices, lack of proper supervision and inadequate training are the issues that need to be addressed.

Abuse and Misconduct

HPRAC sees a particular risk of harm resulting from abuse and acts of misconduct such as fraud. PSWs are often the primary attendant or caregiver for a client in a home or

¹⁶ Letter from Registered Practical Nurses Association of Ontario (RPNAO) to HPRAC, June 2006.

¹⁷ Diversicare Canada Management Services Co. Inc., Submission to HPRAC, May 2006.

facility. They are often serving clients who are particularly vulnerable because they are frail elderly, have physical or cognitive disabilities or are recovering from an illness or injury.

Numerous instances of serious abuse reported to HPRAC included: psychological abuse such as the social and or physical isolation of the client; verbal and emotional abuse including insults and threats of harm or abandonment; withholding services and/or the essentials of life including medications and access to health care; physical and/or sexual abuse including inappropriate remarks; and fraud in financial matters or coercing changes to the client's will or powers of attorney. It was impossible for HPRAC to document the frequency of such abuse, but patients, clients and employers all spoke of these matters, and there is a record of police intervention and jurisprudence associated with such abuse.

HPRAC notes that the employer is responsible for the actions of its employees, and must have a zero tolerance policy regarding abuse. HPRAC also notes the importance of in-service training for staff to ensure they understand how to deal appropriately with clients.

Underreporting of Abuse and Misconduct

HPRAC also heard that cases of abuse involving PSWs may be substantially underreported. For example, the ARCH Disability Law Centre reports that complainants are reluctant to formally report abuse for fear of reprisal such as further abuse or loss of services. The fear of reprisal may be heightened by the client's physical vulnerability, the absence of alternative providers, and instances of employer inaction regarding an abusive staff member.¹⁸

That the incidence of harm is likely underreported was echoed by other observers in regard to seniors. Mohawk College advised that "seniors are particularly vulnerable as they are very trusting...and would find it difficult to report any concerns that they had."¹⁹

Officials from Diversicare Canada Management Services told HPRAC that, "Sometimes [seniors are reluctant to bring forward or confirm abuse] because of a misguided attachment to the caregiver...[a] resident...[may attempt to] rationalize or explain the actions of the caregiver."²⁰

Harm resulting from Lack of Information regarding Employee Misconduct

There is an additional risk of harm resulting from the inability of employers to perform full credential and work history reviews of PSW candidates. There is no database or registry of PSWs that would allow employers to obtain information about qualifications, work experience or reasons for leaving previous employment. Currently, employers can only access a criminal record check.

¹⁸ For reasons of limited staff availability or rules governing unionized work places.

¹⁹ Mohawk College, Submission to HPRAC, March 2006.

²⁰ Diversicare Canada Management Services Co. Inc., Submission to HPRAC, May 2006.

Many employers commented about shortcomings in the *Ontario Labour Relations Act* and the arbitration process. For example, they expressed the view that barriers exist to the disclosure by employers of negative information about incidents involving a PSW or their dismissal. The high threshold required to prove abuse coupled with a desire for a speedy resolution to an incident often encourages employers to offer a "buy out" to an employee rather than follow the procedures that would lead to dismissal. The "buy out" would be accompanied by a confidentiality agreement.

Overall, HPRAC concludes that in the work of PSWs there is a risk of physical and psychological harm for patients when there is inadequate professional supervision, when clients do not have adequate recourse, or when employers are lax in ensuring that standards are met. HPRAC concludes that enhanced supervision, adequate recourse for clients and patients, improved PSW training and the application of diligent employer standards are appropriate methods of addressing the issue of harm.

3. 3 Membership's Support and Willingness to be Regulated

To be ready for self-regulation, a profession must show a willingness to be regulated. Members of the profession must support self-regulation for themselves, with sufficient numbers and commitment that widespread compliance is likely. Members of the profession must be sufficiently numerous to staff all committees of a governing body and be willing to accept the full costs of regulation. At the same time, the profession must be able to maintain a separate professional association.

While there are a number of fledgling organizations emerging, PSWs do not have an association that is fully representative of its membership.

PSWs as a group have not convincingly demonstrated to HPRAC widespread support, willingness or likelihood of compliance with regulation. The National Association of Certified Caregiver Personal Support Workers (NACPSW) has expressed interest in the regulation of its members and has asked to be given the duties of a regulatory body. Reportedly 2,214 of NACPSW's approximately 5,000 members live in Ontario.

The NACPSW functions as an advocacy association and as a voluntary regulatory body by offering its members continuing education, professional development opportunities and by liaising with government on behalf of its membership. The association also states that it sets standards and guidelines for practice and handles complaints from clients and employers.

The Ontario Association of Personal Support Workers and Health Care Aides (OAPSW & HCA) is another association representing PSWs. Compared to the NACPSW, the OAPSW & HCA is relatively new and less organized. Discussions with the OAPSW & HCA have led HPRAC to believe that its members seek credibility and respect as a member of the health care team, but that the full impact of self-regulation may not be fully appreciated.

During public consultations HPRAC heard from a small number of PSWs who supported regulation under the *RHPA*, but HPRAC is unable to ascertain whether they are representative of the majority of PSWs. PSWs who spoke to HPRAC during public hearings and focus groups generally demonstrated a lack of understanding of the costs, responsibilities and complexities of professional self-regulation.

HPRAC heard that PSWs, who are low wage earners and often work part-time, would not be able to sustain the costs of regulation as a separate college or as part of an existing college. One respondent suggested that PSWs be regulated under the College of Nurses of Ontario (CNO) so that costs might be affordable, but the CNO has not endorsed this position.

HPRAC concluded that PSWs are not sufficiently familiar with the requirements of regulation, or adequately organized or equipped to support self-regulation.

3.4. Leadership's Ability to Favour the Public Interest

For self-regulation, the profession's leadership must show that it will distinguish between the public interest and the profession's self-interest, and in self-regulating will favour the former over the latter.

HPRAC is confident that the majority of PSWs want to serve their client's or patient's interests. However, the lack of a fully developed professional association representing the majority of PSWs makes it difficult to identify leadership which can ensure that the role of advocacy for the profession is understood as having different goals and requirements than the promotion and protection of the public interest.

3.5 Sufficiency of Supervision

In assessing the adequacy of supervision, HPRAC reviews whether a significant number of members of a profession practice without having the quality of their performance monitored effectively, either by supervisors in regulated institutions, by supervisors who are themselves regulated professionals, or by regulated professionals who assign tasks to the profession under review.

In publicly-funded acute, long-term and community care settings, work is broadly overseen by the facility, the CCAC or the agency-employer. PSWs are generally supervised by a Registered Nurse (RN) or Registered Practical Nurse (RPN). CCACs and long-term care homes themselves are subject to accountability agreements with the Ministry of Health and Long-Term Care, or are subject to regulations, standards and rules under the *Long Term Care Act*.

Supervision in private retirement homes is more variable, with no regulatory oversight.

Long-Term Care Homes

Long-Term Care homes have the most formalized regulatory structures with the highest

level of supervision of PSWs. Despite this, Nipissing MPP Monique Smith's 2004 report indicated that a number of homes were experiencing challenging staffing issues that raised concerns about PSW supervision.

For example, we visited homes where there was one registered nurse (RN), one registered practical nurse (RPN) and four Health Care Aides for 160 residents on the night shift. In addition, long-term care homes are...staffed by a mix of part-time nurses, health care aides and personal support workers resulting in 'casualization' of this workforce.... This results in greater staff turnover and the opportunity for increased error.²¹

HPRAC heard that ratios are generally more moderate. In discussions with employers, HPRAC was told that some homes have PSWs caring for as few as nine residents under the supervision of an RN or RPN. The average ratio is closer to 11:1 or 13:1. In general, an RN will have 60 residents under their care and supervision, and an RPN will have 45. Employers commented that funding issues drive the numbers of supervisors.

Community Care

HPRAC heard that in community and home care settings, the PSW most frequently works at some physical distance and with limited direct oversight from the supervising health professional. Supervision is often indirect, occurring through telephone meetings and chart review. HPRAC heard that standards required of employers need to be strengthened, with employers taking more responsibility in ensuring consistent standards across settings.

Given that supervision in home care is often indirect, this places the onus on the CCAC or CSS to ensure that service providers have the relevant standards and procedures in place to ensure adequate supervision and the delivery of high quality care.

Private Employment

HPRAC heard that supervision of PSWs in retirement homes varies widely. Some have registered professional staff supervising PSWs while others were reported to have PSWs working on their own, including administering medications. HPRAC notes that people currently entering retirement homes are increasingly likely to be frail elderly with cognitive disabilities and continuing care requirements.

Private retirement homes belonging to the Ontario Retirement Communities Association (ORCA), voluntarily subscribe to a set of professional operating standards, including human resource practices "essential to fulfilling legislated obligations for the maintenance of safe, comfortable living environments for residents." Members adhere to

²¹ M. Smith, *Commitment to Care: A Plan for Long-Term Care in Ontario*, 2004 p 21. HPRAC notes that the Minister of Health and Long-term Care has responded with an announcement of increased funding for 3,140 full-time equivalent (FTEs) positions in the LTC home sector, including 682 FTE nursing positions.

a Code of Ethics.²² This sector is not regulated, however, and there is no monitoring of adjunct care provided to residents.

RN/PSW ratios and RPN/PSW Ratios

HPRAC heard that employers are concerned about nurse-to-PSW ratios, and that they want to ensure that they have adequate numbers of nurses supervising PSWs in order to respond to patient acuity. The range of health issues is not identical in the different settings, and while ratios of RNs-to-PSWs and RPNs-to-PSWs are important, they should not be viewed in isolation. Employers stressed that the ideal requirement is for a range of ratios based on acuity of patients and the complexity of care required rather than a rigid numerical formula.

American researchers studying long term care facilities in the United States concluded that staffing type is an effective predictor of high-quality care processes. Facilities with a higher mix of licensed practical nurses compared to nursing assistants whose role is comparable to a PSW's, were found to have a broader range of positive outcomes. A separate study showed that a lower proportion of regulated nursing staff was linked to increased medication errors and wound infections.²³

In Canada, "research on staffing models...has shown the clear link between knowledge and skill levels and patient outcomes. The evidence is available in all sectors of health care including hospital, long-term care, and community settings. For example, hospitalized patients [with more care from RNs]...had shorter stays, and lower rates of urinary tract infections, pneumonia, shock, cardiac arrest, and failure to rescue...as well as lower rates of wound infections and medication errors."²⁴

However, in all sectors, HPRAC heard concerns about imposing fixed ratios. Employers indicated that they need a range of ratios based on patient and resident acuity and profile. Employers also noted that rigid ratios limit creativity of employers in introducing new care models or alternate service approaches.

Some also expressed concern that establishment of minimum staffing ratios will drive up wages. Overall, employers stressed that there needs to be an emphasis on minimum care levels, not minimum staffing levels.

Stakeholders also identified a need for significantly enhanced training of RNs and RPNs to improve their supervisory skills. Registered professionals need increased focus in their training on staff leadership.

PSWs as part of the Health Care Team

In publicly funded venues (hospitals, long-term care, home and community care), PSWs

²² ORCA Website, Accessed September 5, 2006.

²³ Letter from the College of Nurses of Ontario (CNO) to HPRAC, June 2006.

²⁴ Letter from the Registered Nurses Association of Ontario (RNAO) to HPRAC, June 2006.

are generally supervised by an RN or RPN, with each patient or client having either a treatment plan or a plan of care. These are generally developed by nursing staff in consultation with other regulated health professionals familiar with the client. With the plan in place, task assignments are made for the provision of personal and clinical care services. PSWs assist in implementing the care plan.

However, some interveners summed up the transfer of authority as a “broken process” moving from RNs to RPNs to PSWs.

A number of stakeholders suggested that PSWs need to be a more central part of the care team, and should be equipped with full baseline information so they can report changes in the patient’s or client’s condition. Some suggested the need for an integrated care model. Although they do not perform assessments, some point out that PSWs’ regular interactions with clients and responsibilities for contact reports are key inputs to the development and revision of care plans. This is important to ensure that changes in condition observed by PSWs are taken into account as the care plan is adjusted.

Responses to HPRAC’s interviews with employers on this topic were mixed. Some employers indicated that PSWs are not seen as a major part of the health care team - it was not their job. They were there to carry out direction, since that is what they have the training to do. Any reporting they did would be routine and technical through charting. Other employers stated that PSWs are already involved in care teams.

HPRAC heard from long-term care homes that there are standardized methods of reporting changes in patient condition and monitoring at-risk individuals. In long-term care facilities, reporting is handled through flow charts and by documentation of technical steps in the care plan. In home care, employers said that changes in the patient’s response to care must be reported, and that in-service training is provided to ensure the PSW is able to provide appropriate reporting to his or her supervisor and then to the care manager. HPRAC heard that there is little observational reporting in retirement homes.

Delegated Acts

Controlled acts are those procedures that are restricted under the *RHPA* to members of a regulated health profession. The type and number of controlled acts authorized to a regulated health practitioner depend on the scope of practice for his or her profession.

Where very specific criteria have been satisfied, PSWs may be delegated controlled acts under (direct or indirect) supervision, most often by a Registered Nurse (RN) or a Registered Practical Nurse (RPN). Other regulated health practitioners who might have occasion to delegate to a PSW include Physiotherapists and Registered Respiratory Therapists. The following chart illustrates the current relevant controlled acts authorized to these professions.

Who can do what...

Controlled Act	College		
	CNO (Nurses)	CPO ²⁵ (Physio- therapists)	CRTO (Respiratory Therapists)
# 2 Procedures below the dermis...	●		●
# 4 Moving joints		●	
# 5 Administering substance by injection or inhalation	●		●
# 6 Putting an instrument, hand or finger into a body orifice or artificial opening into the body...	●	● ²⁶	● ²⁷

Most frequently, PSWs perform controlled acts that involve:

- Controlled Act #5 - administering a substance by injection or inhalation (for example, administering insulin or oxygen therapy).
- Controlled Act #6 - putting an instrument, hand or finger into a body orifice or artificial opening into the body. For example, applying prescribed cream or ointment to the mouth, administering Gastric and Gastric J tube feedings, suctioning, administering pre-measured oral medications, suppositories, bladder catheterization, colonic irrigations or enemas.

PSWs have sometimes been made responsible for maintaining medication inventories or supervising exercise routines.²⁸

Exceptions

Section 29 (1) (d) and (e) of the *RHPA* provides two exceptions to the controlled act regime. Exceptions are permitted when any person is:

1. Treating a member of his or her household.
2. Assisting a person with routine activities of living.

The second exception gives PSWs the authority to perform an act or task that is otherwise controlled when it has been established as a routine activity of living. The CNO advises that procedures are considered to be routine when the need for, response to, and outcomes from, performing the procedure have been established over time and are quite predictable. It cautions that: "The same procedure may be a routine activity of living in one set of circumstances and part of a therapeutic plan of care in another."²⁹ The CNO

²⁵ College of Physiotherapists of Ontario.

²⁶ Tracheal suctioning only.

²⁷ Intubation and suctioning only.

²⁸ Ontario Job Futures. 3413 Nurse Aides, Orderlies and Patient Service Associates. Government of Ontario. <http://www1.on.hrdc-drhc.gc.ca/ojf/ojf.jsp?lang=e&section=Profile&noc=3413>. Accessed December 13, 2005.

²⁹ CNO, *Practice Guideline: Working With Unregulated Care Providers*.

further informs that, while suctioning the airway of a child with a permanent tracheostomy is a predictable part of a child's routine, the same procedure is no longer routine if he or she develops pneumonia. The need, response and outcome will have become unpredictable during the illness.

There was consensus that the supervision of delegated acts is an important and serious matter in the provision of care by PSWs. Delegated acts were seen to carry the most pronounced risk of harm if improperly carried out.

3.6 Complaints Processes

In all health care settings, patients, clients and their families have shown an interest in becoming more informed and involved in managing their own care. This has placed new demands on care providers for clear communication, individual and system accountability, and the need for appropriate mechanisms to resolve complaints.

For each of the province's long-term care homes, the Ministry of Health and Long-Term Care (MOHLTC) posts information on reported concerns that have been investigated and verified.³⁰ Types of concerns include: activation, dietary, environment, facility organization or administration, financial, medical care, resident care, resident rights and abuse. In 2005, MOHLTC received 2,791 complaints from residents of Ontario's Long-Term Care Homes. The respondent to the allegations and the extent of involvement of PSWs in these cases is unknown, as the data does not identify job title or responsibilities.

Ontario's forty-two CCACs are also required to report on the volume of complaints occurring within the system. Concerns that have been resolved by the case manager and or team assistant are not reported through this mechanism. In 2004-05, MOHLTC received reports from thirty-eight CCACs.³¹ In that year, 4,028 complaints were registered. Some clients may have made several complaints. In 2005, the Ministry provided a new tracking tool to differentiate between complaints about quality of service and complaints about CCAC decisions. (For example, the types and hours of service for which a client is eligible).³² As yet, this tool has not been fully integrated by CCACs into their operations.

Meaningful data for private home, retirement home or attendant care are unavailable.

In long-term care and home care, the MOHLTC is instituting new mechanisms to improve the complaints process and to provide consumers with better information on quality of care. For example, in response to the Smith report, MOHLTC has launched a public website that provides seniors, families and caregivers with information on individual long-term care homes and their record of care. The Ministry has also

³⁰ Public Reporting on Long-Term Care Homes website.

http://www.health.gov.on.ca/english/public/program/ltc/26_reporting.html

³¹ Four CCACs did not report on the complaints they received.

³² MOHLTC, *Community Care Access Centres Complaints Reporting Policy*, May 2005. Other CCAC decisions relate to a person's eligibility for services or termination of services.

introduced a toll-free Action Line for the public to register complaints or concerns about long-term care homes. As well, it has funded resident and Family Councils to improve community engagement and provide residents and families with a greater voice in the day-to-day life of long term care homes.

In response to the Hon. Elinor Caplan's Report *Realizing the Potential of Home Care, Competing for Excellence by Rewarding Results* (Caplan report), among other measures, the Ministry is expanding the MOHLTC Action Line to provide the public with access to an independent third party to hear home care complaints. There will be up to five independent complaints coordinators to hear client complaints, address concerns and track trends. CCACs will also be directed to inform their clients that they can request a change in service provider without fear of loss of services. Appendix 1 provides a more complete description of MOHLTC's responses to the Smith report and the Caplan report.

3.7 Education and Training

Typically, personal support workers prepare for the job in one of two ways - through in-service (employer-based) training, or in classroom programs offered by community colleges, boards of education, private colleges and not-for-profit organizations.

PSW programs are offered at twenty-two community colleges in Ontario. The programs are usually taught over two academic terms (approximately eight months). Reportedly, 2,272 students graduated from PSW programs in 2002-2003. On average, graduates spent 384 hours on in-class theory³³ and 386 hours gaining practical experience for a total of 770 program hours. Individuals working as personal attendants may have completed a program that is similar to that of the PSW but is shorter in duration.

In 1997, the Personal Support Worker Program consolidated and replaced five courses in home care training.³⁴ The consolidated program was based on the standards and model PSW curriculum approved by the Ontario Ministry of Training, Colleges and Universities (MTCU), MOHLTC and the Ontario Community Support Association (OCSA). In 2005, MTCU updated its standards for programs graduating PSWs.

Ontario's private career colleges also offer PSW courses. Private colleges are overseen by the MTCU. They are not required to match the community college program standards, but recent evaluations indicate that most meet all core elements.³⁵ The National Association of Career Colleges (NACC) provides a core curriculum against which career

³³ Theory hours include non-vocational components that teach skills identified by Human Resources and Skills Development Canada as requirements for employability across Canada.

³⁴ This program replaced the Home Support II and III program, the Health Care Aide program, Attendant Care Training and Respite Worker Training, resulting in the emergence of the title of Personal Support Worker. Ontario Association of Community Care Access Centres, Ontario Community Support Association, Ontario Home Health Care Providers' Association. *The Role and Value of Homemakers/Personal Support Workers in the Health Care System: A Discussion Paper*. November 2000.

³⁵ A recent evaluation completed by Assessment Strategies Incorporated (which has experience evaluating equivalencies for RN and RPN examinations) found the NACC program guideline to be compatible with the community college standards.

colleges may measure their programs. While it is not mandatory for career colleges to implement the NACC curriculum, most of the 116 private career colleges currently offering PSW programs in Ontario adhere to NACC's common standards. The Ontario Association of Career Colleges (OACC) also noted that its members' programs incorporate the 1997 PSW program standards and model curriculum as do school boards and not-for-profit educational facilities.³⁶

The NACC program is approximately 640 hours in duration, with 355 hours spent in the practicum component and 285 hours spent learning theory. Since 1998, approximately 17,000 PSW graduates have passed the final examination offered by NACC.³⁷ Four-thousand students graduated in 2005.

Twenty-one boards of education offer PSW courses through adult continuing education programs. Courses contribute to the completion of a high school diploma. The Toronto District School Board graduates approximately 150 personal support workers a year. The Simcoe County School Board provides a personal support worker program connected with Georgian College.³⁸ Typically, students enrolled with a board of education will spend 540 hours in the classroom and 270 hours completing their practicums for a total of 810 program hours.

In-Service Training

Most employers provide orientation and training or skills upgrading relevant to the specific needs of their clients. A large proportion of PSWs have received in-service training through their employers, either through direct on-the-job training or through formal programs offered by non-governmental health organizations. Employers may also subsidize costs for employees for skills upgrades acquired through formal education. PSWs also may be enrolled in an education program as part-time students while working on a part-time basis.

Stakeholders identified several gaps in the PSW skills set, including:

- Teamwork, communication and literacy skills.
- Understanding of human growth and development across the lifespan.
- Understanding of people living with disabilities.
- Knowledge of specific care issues associated with palliative care, Alzheimer's and dementia.

Representations made to HPRAC during phase II confirmed that additional PSW education and training in these areas would be beneficial for PSWs who work with clients with complex care needs.

³⁶ Ontario Association of Career Colleges (OACC), Presentation to HPRAC, May 2006.

³⁷ National Association of Career Colleges. *About NACC*. <http://www.nacc.ca/about.htm>. Accessed December 14, 2005; Interview with the Private Colleges Branch of the Ministry of Training, Colleges and Universities. December 13, 2005.

³⁸ Simcoe County District School Board. *School to Work and OYAP*. http://www.scdsb.on.ca/programs/school_to_work.cfm. Accessed December 14, 2005.

Several stakeholders identified a role for employers in providing training in specific skills beyond the scope of the core curriculum. A number of respondents also indicated that continuing education opportunities should be provided by employers so that PSWs can stay current with relevant best-practices and legislation; such continuing education would ensure an adherence to provincial standards.

Monique Smith's report also recommended additional training requirements for PSWs in the long-term care environment. At a minimum, staff should be trained to understand the needs of the elderly, abuse, communication skills, dementia and palliative care.³⁹

The Caplan report noted that there has been no evaluation of PSW courses, and recommended that the MOHLTC and MTCU evaluate PSW training programs including both length and content of the curriculum. The MOHLTC response included, among other measures, expanding "the use of the \$10M Personal Support Worker Training Fund in order to meet the growing need of the sector". The response did not specifically address an evaluation of PSW courses.⁴⁰ (See Appendix 1 for highlights of MOHLTC's response to the Caplan report).

3.8 Educational Standardization

Many stakeholders said that concerns regarding the abilities of PSWs, their deployment in the workplace and status as members of care teams could be resolved by standardizing educational outcomes.⁴¹

In fact, there was general support regarding standardized education for PSWs as a recommended option. Suggestions for standardization include:

Standardized Curriculum. Most stakeholders thought that the MTCU should mandate a basic core curriculum for career and community colleges and boards of education that offer PSW training, with mandatory accreditation of these programs. In this way, graduating PSWs would have a uniform standard of competency and minimum skill-sets that employers could rely upon. However, employers noted that there should be meaningful consultation to ensure that the curriculum meets the needs of the workplace. Some employers said they have had nominal involvement at best in recent changes to the curriculum, and find that program outcomes do not meet current employment needs.

Some stakeholders were concerned that standardizing the curriculum for PSWs could increase educational costs, although HPRAC also heard views that program costs need not increase if the length of the programs remained unaltered.

³⁹ Smith, Monique. *Commitment to Care: A Plan for Long-term Care in Ontario*. Ontario Ministry of Health and Long-Term Care. 2003.

⁴⁰ *Choosing Quality, Rewarding Excellence, Ontario's Response to the Caplan Report on Home Care*.

⁴¹ For example, issues regarding the assignment of PSWs or their role as care team members.

Standardized Mandatory Examinations. A majority of the participants in HPRAC's review were in favour of establishing a standardized certification exam. Many agreed with the need to include a practical component to the examination. Others pointed out that, unless it was restricted to new graduates, the introduction of a mandatory standardized examination could create a supply crisis. Concerns regarding language issues and the likely reticence of some established workers to taking an exam were raised. Some also expressed uncertainty regarding which organization would best administer such an exam.

HPRAC concludes that the development of standardized educational outcomes for all providers of PSW training programs would be valuable. HPRAC is not recommending a province-wide certification examination for entry to practice at this time, as there are significant concerns regarding proficiency in written English, questions relating to the certification of existing PSWs, and no consensus regarding which organization would best administer such an exam. Administrative costs that might be attached to a standardized mandatory examination could also represent a barrier to entering the job market as a PSW.

3.9 Economic Impact of Regulation

The establishment of a self-regulatory college includes financial obligations for members of a profession. The implications of this increased financial burden and the ability of members to sustain these costs on a continuing basis must be considered when assessing whether the PSW occupation is suitable for designation as a self-regulating profession. HPRAC has concluded from its interviews that the costs of regulation may not be well understood and may be prohibitive for many PSWs. This may have the unintended consequence of reducing the size of the workforce at a time when demand for PSW services continues to grow.

4. The Registry Option

In forming its conclusions regarding regulation of PSWs under the *RHPA*, HPRAC also considered a number of alternative options including the establishment of a registry as a less restrictive form of regulation.

HPRAC's initial consultations sparked significant debate regarding a registry as an alternative to full regulation under the *RHPA*. Proponents thought that a registry may meet the need for enhanced public transparency, and that employers might benefit from access to work history of personal support workers and knowledge of why an employee left employment or if he or she was fired for cause. These observations led to further investigation of the registry option. Those supporting the concept also saw it as a resource for employers performing reference checks, and a tool for public safety. Some believed that the development of a national PSW registry for incidents and dismissals could also provide a means of reporting abuse.

There were many that were not in favour of a registry. A number of employers questioned the need for a registry given enhancements to current legislation and safeguards requiring abuse to be reported and investigated by the Ministry. Others noted that the arbitration process makes it difficult to prove cause for dismissal, and often leads to employers compensating employees and agreeing to confidentiality to ensure termination. Most thought that a registry would not change this, and incidents of abuse would not be affected.

HPRAC further investigated the U.S. experience with health aide registries which are required for an agency employer to receive reimbursement from Medicare. Registries in the U.S. are in the public domain and are accessible to employers and usually to members of the public. Complaints, employment history and disciplinary actions are recorded in the register. To register, the home health aide must meet a number of requirements.

U.S. Federal law requires home health aides to pass a competency test covering a wide range of areas: communication; documentation of patient status and care provided; reading and recording of vital signs; basic infection-control procedures; basic bodily functions; maintenance of a healthy environment; emergency procedures; physical, emotional, and developmental characteristics of patients; personal hygiene and grooming; safe transfer techniques; normal range of motion and positioning; and basic nutrition. Federal law suggests at least 75 hours of classroom and practical training, supervised by a registered nurse. Training and testing programs must meet the standards of the Center for Medicare and Medicaid Services. State regulations for training programs vary, but certification is required to demonstrate that the individual has met industry standards.⁴²

From HPRAC's investigations, the Council found that the form and function of a possible registry could focus on three purposes:

- A *Certification Registry* which would record the successful completion of a certified PSW program. Its purpose - to track vocational competency.
- An *Incident Registry* which would record performance issues occurring during a worker's employment as a PSW. Its purpose - to bring to light performance problems.
- A *Dismissal Registry* which would record the dismissal of a PSW by an employer, thus serving as a registry to track employment termination.

For a registry to be viable, the majority of stakeholders were of the opinion that listing on the registry should be mandatory, and that the registry be created and maintained by a central agency and updated regularly. The benefits would include having up-to-date information on a worker's qualifications, continuing education, certified competencies, work performance, and substantiated complaints regarding quality of service. The challenge would be instituting mechanisms for tracking and maintaining of information for each PSW.

⁴² U.S. Department of Labor, Bureau of Labor Statistics <http://www.bls.gov/oco/ocos165.htm> Accessed on September 20, 2006.

For their part, employers, including individuals, would be required to file reports. Potential employers would also be required to use the registry database for purposes of reference checks before hiring.

The compulsory nature of employers' participation in filing reports proved controversial. Matters related to enforcement and penalties for failure to comply remain unresolved. Other controversial elements of a proposed registry include the potential to impact the workforce, specifically by excluding capable workers who have not graduated from a certified PSW program, and by impacting the individual PSW's right to privacy. A registry would also need to determine the number of years a complaint history was listed before it could be expunged.

Some suggested that a certification registry in conjunction with a required educational program might be a first step with voluntary use by employers.

A prerequisite to launching a certification registry would be to establish uniform minimum entry-to-practise standards for PSWs. This would need to address the treatment of equivalent credentials and competencies in order to avoid the exclusion of a significant part of the current workforce. There was little discussion or agreement on who should accredit and or implement this process.

Whether voluntary or mandatory, whether implemented in full or in part, most agreed that significant costs would be entailed in the operation of a registry. The idea that PSWs might shoulder the cost was not supported.

HPRAC examined this approach for Ontario and observed that there are a number of issues which would have to be addressed in the creation of a registry:

1. Specific legislation would be required to implement a registry, including provisions for certification, confidentiality, complaints, reports and hearings and due process.
2. Either the province or a willing host operating under a contract with the Ministry would have to undertake the responsibility for managing and maintaining the register.
3. An independent board would need to be established at arm's length from employers, educators and the Ministry to govern the operations of the registry.
4. Province-wide certification examinations would have to be established to qualify individuals for inclusion in the register.
5. Confidentiality issues relating to both patients and workers would require examination;

6. A registry could be a disincentive to personal support workers, if it referenced only negative reports rather than positive achievements.
7. A registry may or may not be able to address issues in private care and retirement homes which are currently unregulated.
8. A registry would be a high-cost item and would need to be implemented over a phased period.

Given the potential costs and impacts of establishing a registry versus the potential overall benefits, HPRAC did not find a compelling argument for creating a PSW registry at this time.

5. Independent Living and Attendant Care

Attendant care agencies also employ PSWs. These agencies primarily administer outreach attendant care and assisted living programs for the adult disabled community living in supportive housing. They also play a role in the province's Direct Funding Program (DFP). Attendant care is distinct from other community home care services. While the functional tasks may be similar, attendant care is based on the independent living model, not a health care model.

In the Direct Funding Program, the province allocates funds directly to the disabled program participant or a family member.⁴³ The client is the employer and is responsible for hiring their own attendants and directing their own services. The DFP allows for personal care, home making, shopping, and meals, personal and social support. Under the Ontario Direct Funding Regulations, the role of the attendant and the nature of the services he or she provides are well defined.⁴⁴

In outreach attendant care, services are provided through an agency to persons with a disability in their homes, workplaces or other settings. A set number of hours and services is contracted for, but services are not available 24 hours a day.⁴⁵

In Support Service Living Units, a cluster of apartments enables attendant care services to be provided to a group of people with disabilities in their homes. Specific hours of service are contracted for, but attendants are present on site 24 hours a day and are available on an emergency basis.

⁴³ The Direct Funding Program requires that the person with a disability (or a family member) set up a business with the Canada Customs and Revenue Agency. Funds are based on need and allocated in terms of service hours. The maximum is 182.5 hours per month. This amounts to a maximum of 6 hours per day with flexibility on how and when to use the hours. The Centre for Independent Living Toronto, 2000.

⁴⁴ MCSS Act, Ontario Regulation 367/94.

⁴⁵ Human Resources and Social Development Canada (HRSDC)

<http://www.hrsdc.gc.ca/asp/gateway.asp?hr=en/cs/sp/edd/reports/1999-000363/page08.shtml&hs=pyp>.

Accessed September 25, 2006.

In these situations, attendant care workers provide support with activities of daily living including assistance with bathing, dressing and eating, as well as work-related activities. They also may perform controlled acts by exception, meaning that delegation from a regulated health care professional is not required where an activity of daily living involves a controlled act.

In the course of its phase II consultations, HPRAC heard from many more persons living independently with disabilities. The disabled include people who have an unusual limitation on their physical function, their thinking and or their emotional expression. A person may become disabled as a result of birth anomalies, injury or illness.⁴⁶ Their representations spoke to the differences between attendants and PSWs, and highlighted unintended consequences of any potential move to regulate PSWs.

Controlled Act Exceptions

The controlled act exceptions, built into the *RHPA*, for activities of daily living recognize the importance of attendant care. The Ontario Community Support Association (OCSA) has observed that the risk associated with the routine tasks performed by attendants "is generally no greater than the risk incurred if the client were to perform the activity him or herself."⁴⁷ The Independent Living Service Providers noted that "...this exemption has served attendant care employers and clients very well since 1991."⁴⁸

However, if attendants were included with PSWs in a newly-regulated profession, the exception may no longer apply.⁴⁹

Attendant Training

Community colleges recognize the distinction between attendant care workers and PSWs with fewer modules being completed by students wishing to become attendants. This acknowledges the value of the training and job supervision provided by the self-manager.

Access to Services and Quality of Care

The Attendant Consumer Action Coalition (ACAC), as well as individuals contacting HPRAC, expressed concern that regulation under the *RHPA* would limit the choices available to DFP participants thus limiting their access to services. The outcome might be to limit the number of people who could be served by attendant service programs. It could also impact people waiting for this service.⁵⁰

⁴⁶ J. Snow, *Personal Assistance: What It Is and Is Not*, 2001, p 1

⁴⁷ Ontario Community Support Association (OSCA) Submission to HPRAC, March 2006.

⁴⁸ Independent Living Service Providers (ILSP), Submission to HPRAC, March 2006.

⁴⁹ Ibid.

⁵⁰ Attendant Care Consumer Action Coalition (ACAC), Presentation to HPRAC, May 2006.

The ACAC asserts that disabled persons participating in the DFP are amply protected by having stable, predictable needs, and are in a position to hire, train and self-direct attendants. Choice and control give program participants "more protection from harm...than any kind of regulation could ever provide."⁵¹ Similarly, quality control is assured.

Complaints Process

Some stakeholders have criticized attendant service programs for inadequate client complaints procedures and recourse mechanisms. Some of the issues brought to HPRAC's attention included:

- Lack of consumer control over the selection and assignment of personal care providers; this currently resides with the management organization.
- Gross lack of accountability and quality control over care providers.
- No independent complaint process.
- No accountability within the existing complaints process for the timely or satisfactory resolution of complaints.
- No effective recourse for unresolved complaints. Litigation is too costly, and the Health Services Appeal and Review Board [HSARB] process is lengthy and lacks judicial power.

Those expressing discontent typically received services from funded agencies under the 24-hour independent living model.⁵²

In response to the discontent expressed, HPRAC urges the Minister of Health and Long-Term Care to undertake a program review to ensure that:

- Transfer payment agencies delivering 24-hour independent living services are operating within an appropriate accountability framework guided by the principles on which the attendant service programs are founded.
- Client satisfaction surveys occur regularly to identify systemic issues which may otherwise go unreported.
- Clients have access to a responsive complaints process, including a toll-free hotline similar to the MOHLTC Action Line.

⁵¹ Ibid.

⁵² Where Outreach and SSLU are funded as Transfer Payment Agencies.

6. Recommendations

Regulation

- 1. HPRAC recommends that Personal Support Workers not be regulated under the *Regulated Health Professions Act, 1991* as they do not meet the requirements for regulation.**
- 2. HPRAC recommends that a Registry for Personal Support Workers not be required as an alternate to regulation under the *Regulated Health Professions Act, 1991*.**

Education and Training

- 3. HPRAC recommends that the Minister of Health and Long-Term Care recommend that the Ministry of Training, Colleges and Universities develop mandatory standardized educational outcomes for PSW educational programs in community colleges, career colleges, not-for-profit organizations and boards of education, and that the involvement of employers in establishing curriculum and educational outcomes to meet workplace needs is enhanced.**
- 4. HPRAC recommends that regulated health profession Colleges whose members supervise PSWs should :**
 - a. Develop clear guidelines for supervision.**
 - b. Provide additional training and require competencies in supervision and staff leadership from their members.**

Attendant Care

- 5. HPRAC reiterates its recommendation from the New Directions report to the Minister of April, 2006 that there should be no change to Section 29 (1) (e) of the *RHPA* that excepts individuals “assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27 (2).”**
- 6. In addition, HPRAC recommends that the Minister of Health and Long-Term Care undertake a program review to ensure that:**
 - a. Transfer payment agencies delivering 24-hour independent living services operate within an enhanced accountability framework.**
 - b. Client satisfaction surveys occur regularly with the view to identifying systemic issues which may otherwise go unreported.**
 - c. Clients have access to a responsive complaints process, including a toll-free hotline similar to the MOHLTC Action Line.**

APPENDIX 1

Recent Actions by MOHLTC

In response to MPP Monique Smith's Report, *A Commitment to Care: a Plan for Long-term Care in Ontario (Spring 2004)*, the MOHLTC has implemented a number of reforms to improve quality of care in long-term care homes. These measures include:

- An increase of 3,140 full-time equivalents (FTEs) in long-term care homes, including an increase of 682 FTE nursing positions.
- Regulations to ensure 24-hour RN coverage and return to two baths per week per resident.
- Tracking staffing by category at 593 homes.
- Instigation of unannounced visits, including dietary, environmental and post-occupancy compliance visits, or complaint investigations.
- Implementation of two new standards for skin care and wound care.
- Development of a risk management framework along with risk-based auditing tools.
- Institution of measures for tougher enforcement of MOHLTC's requirements for residents' rights, care and services by the Ministry's Compliance and Enforcement Unit (CIEU).

In order to address complaints, provide opportunities for residents to report abuse and unsatisfactory care, and to identify facilities' records of care, the MOHLTC has:

- Launched an Action Line which has resulted in a 30% increase in complaints. Complaints are forwarded to the regions for immediate action. A Regional Compliance Advisor contacts complainant within two business days. Where warranted, an investigation will occur within 20 days. Urgent complaints receive priority. Urgent complaints are escalated through the system after hours and on weekends.
- Launched a public website (04/11) to provide seniors, families and caregivers with information on individual homes and their record of care. The site includes reports on outcomes of inspections and verified complaints for a 12-month period, and has been recently enhanced to identify MOHLTC sanctions imposed on homes (e.g. suspension of admissions) in real time. Unfortunately, it does not record enhancements in service or positive developments in the field.

In response to Hon. Elinor Caplan's Report *Realizing the Potential of Home Care, Competing for Excellence by Rewarding Results* (May 2005), the MOHLTC is instituting the following measures to improve patient safety, quality of care and enhance accountability. Measures to be implemented, among others, include:

- Promotion of continuous quality improvement by expecting all CCACs and service providers to be accredited by recognized bodies, such as the Canadian

Council on Health Services Accreditation (CCHSA), within a designated timeframe, through the development of a centralized pre-qualification program for service providers, and through development of criteria to determine which agencies qualify for preferred provider status – recognizing excellent practices in the RFP process. The MOHLTC will also identify and support home care best practices, service innovations, benchmarks and outcome-based quality service models.

- The MOHLTC Action Line will be expanded to provide the public with access to an independent third party to hear home care client complaints. The Ministry also will provide up to five independent complaints coordinators to hear client complaints, track trends and address concerns. The Ministry will direct CCACs to communicate to clients the process to request a review of their care plan and to reassure them that any issues they raise will not reduce their services and to inform clients that they have the right to request a change in service provider without being fearful that their services will be reduced.
- The MOHLTC is increasing the minimum base wage paid to PSWs under CCAC contracts to \$12.50 per hour. The Ministry will work with CCACs to offer incentives to employers to provide employees with statutory holiday pay, severance and notice of termination. The Ministry will also work with the home care sector to develop targets for full-time and regular part-time PSW positions. While the Ministry notes that a 100 per cent fully trained PSW workforce is not required, the Ministry will direct CCACs to require, as part of their contracts, that service providers hire an adequate number of staff with the appropriate level of training to meet client needs.

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ISBN 1-4249-2153-8 (Print)

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